

3727

## CERTIFICATE OF DEATH

Reg. Dist. No.

03722

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berlin</b>		c. LENGTH OF STAY IN 1b <b>all his life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Branch St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Brittingham</b> Last <b>Brittingham</b>		4. DATE OF DEATH Month <b>3</b> Day <b>26</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>AA</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 2, 1900</b>
9. AGE (In years last birthday) <b>60 yrs.</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gardner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Brittingham</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Purnell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>No</b>	
INFORMANT <b>Mrs. Ida Fassett, Philadelphia, Pa</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Degenerative heart disease</b> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 6, 1956</b> , to <b>March 26, 1961</b> , that I last saw the deceased alive on <b>March 26, 1961</b> , and that death occurred at <b>11:45M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Berlin, Md.</b> DATE SIGNED <b>3/28/61</b>			
ACTUAL SIGNATURE <b>Ivory U. Sully, Jr.</b>		PHYSICIAN'S NAME (Type) <b>Ivory U. Sully, Jr., MD</b> <b>Berlin, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/31/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Berlin, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thornton B. Jolley, Salisbury, Md</b>		24a. REC'D BY REGISTRAR DATE <b>APR 4 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Howard</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OFFICE OF THE ATTORNEY GENERAL

3127

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FORWARDED BY MAIL TO THE ATTORNEY GENERAL

RECEIVED BY THE ATTORNEY GENERAL

BRANCH OF THE ATTORNEY GENERAL

WATER

MADE IN THE UNITED STATES

UNITED STATES OF AMERICA

RECEIVED BY THE ATTORNEY GENERAL

RECEIVED BY THE ATTORNEY GENERAL

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MAYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND													
3728 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05723													
1. PLACE OF DEATH a. COUNTY Worcester				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md b. COUNTY WOR									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) R 2 Berlin				c. LENGTH OF STAY in 1b 3 years				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) R 2 Berlin Md.					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R 2 Berlin Md.				d. STREET ADDRESS R 2 Berlin Route 50				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Russell Turner Cropper				4. DATE OF DEATH MAR 21 1961									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 24, 1905		9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant				10b. KIND OF BUSINESS OR INDUSTRY Automotive Parts				11. BIRTHPLACE (State or foreign country) Berlin Md		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Joseph Cropper				14. MOTHER'S MAIDEN NAME Elizabeth Turner									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. No				17. INFORMANT Address MRS R.T. Cropper, wife, Berlin Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY Occlusion Acute DUE TO (b) Arterio sclerotic CVD DUE TO (c) ? CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH INSTANT.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 3/23/61		22c. NAME OF CEMETERY OR CREMATORY EVERGREEN		22d. LOCATION (City, town, or country) BERLIN		(State) MAYLAND			
23. FUNERAL DIRECTOR Anna A. Burbage Berlin Md				24a. REC'D BY REGISTRAR MAR 27 '61				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

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1. Name of Deceased: *Joseph P. [illegible]*  
2. Date of Birth: *March 10, 1880*  
3. Date of Death: *March 10, 1900*  
4. Place of Birth: *St. Louis, Mo.*  
5. Place of Death: *St. Louis, Mo.*  
6. Cause of Death: *Heart disease*  
7. Duration of Illness: *Several days*  
8. Name of Physician: *Dr. [illegible]*  
9. Name of Medical Examiner: *[illegible]*  
10. Signature of Medical Examiner: *[illegible]*  
11. Signature of Physician: *[illegible]*  
12. Signature of Coroner: *[illegible]*  
13. Signature of Registrar: *[illegible]*  
14. Signature of [illegible]: *[illegible]*  
15. Signature of [illegible]: *[illegible]*  
16. Signature of [illegible]: *[illegible]*  
17. Signature of [illegible]: *[illegible]*  
18. Signature of [illegible]: *[illegible]*  
19. Signature of [illegible]: *[illegible]*  
20. Signature of [illegible]: *[illegible]*



1914

14

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL) and give nearest town Pocomoke City		c. LENGTH OF STAY IN 1b Pocomoke City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William H.P. Matthews		4. DATE OF DEATH Mar. 14, 1961	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 2, 1876
9. AGE (In years less birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Painter	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Matthews		14. MOTHER'S MAIDEN NAME Ellen Warrington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT James H. Matthews		Address Pocomoke City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1958 to 3-14, 1961, that (I) (we) last saw the deceased alive on 3-10, 1960, and that death occurred at 3:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE C.E. Critcher		22b. DATE SIGNED 3-16-61	
22c. PHYSICIAN'S NAME (Type) C.E. CRITCHER		22d. ADDRESS 1000 Chart St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-18-61	
23c. NAME OF CEMETERY OR CREMATORY St. James Cem.		23d. LOCATION (City, town, or county) (State) Pocomoke City, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton - new church, Va -		25a. REC'D BY REGISTRAR DATE MAR 20 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

CERTIFICATE OF DEATH

3000

(M)

Male  
White  
Married  
Born [illegible]  
Died [illegible]  
Cause of Death [illegible]  
Place of Death [illegible]  
Occupation [illegible]  
Residence [illegible]  
Date of Death [illegible]  
Time of Death [illegible]  
Signature [illegible]  
Registrar [illegible]

(1)

[Illegible text, likely a continuation of the form or a separate document page]



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03726

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Snow Hill</b>				c. LENGTH OF STAY IN 1b <b>6 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. 1</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>PETER</b> Middle <b>SAMUEL</b> Last <b>PRUITT</b>				4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 31, 1878</b>	
9. AGE (In years last birthday) <b>82 yrs.</b>		IF UNDER 1 YEAR Months <b>82</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter C. Pruitt</b>				14. MOTHER'S MAIDEN NAME <b>Mary C. Payne</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Miss Mabel I. Pruitt, Snow Hill, Md.</b>		Address <b>R.F.D. 1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic hypertension</b> DUE TO <b>442X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardio-renal disease</b> DUE TO <b>242</b> (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <b>1950</b> to <b>March 6, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 6, 1961</b> , and that death occurred at <b>7:00 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Paul Cohen</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/8/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Paul Cohen</b>				22d. ADDRESS <b>Snow Hill, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-10-61</b>		23c. NAME OF CEMETERY <b>First Baptist</b>		23d. LOCATION (City, town, or county) <b>Pocomoke City, Maryland</b> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Thomas</b>				ADDRESS <b>Pocomoke City, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 13 '61</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **03727**

**3732**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Worcester</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b> c. LENGTH OF STAY IN 1b <b>15 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>217 Cedar Street</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Worcester</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>42 Pocomoke City</b> d. STREET ADDRESS <b>217 Cedar Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <b>CARLTON</b> Middle <b>OTHO</b> Last <b>REVELL</b>				<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>2</b> Year <b>19 61</b>							
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Oct. 15, 1905</b>		<b>9. AGE</b> (In years last birthday) <b>55</b> yrs. IF UNDER 1 YEAR: Months <b>55</b> Days <b>55</b> Hours <b>55</b> Min. <b>55</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Salesman</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Insurance</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Virginia</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Harry R. Revell</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Erin Powers</b>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>---</b>		<b>17. INFORMANT</b> Address <b>217 Cedar Street</b> <b>Mrs Myrtle H. Revell, Pocomoke City, Md.</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>976X Suicide by 2 cream (Pistol Saver)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Returned from under machine, through back into train</b> DUE TO <b>---</b> (c) <b>---</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Loss of job and financial difficulties</b> <b>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>2-2-1961</b> Hour <b>3-2</b> a. m. <b>3-2</b> p. m. <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Home</b> <b>20f. (City or town)</b> <b>Pocomoke</b> (County) <b>Worcester</b> (State) <b>Md.</b>											
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . <b>ACTUAL SIGNATURE</b> <b>N. E. Sartorius, Sr.</b> <b>M.D.</b> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> <b>N. E. Sartorius, Sr.</b> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <b>3-4-61</b>											
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>22b. DATE THEREOF</b> <b>3-5-61</b>		<b>22c. NAME OF CEMETERY</b> <b>Bethany Methodist</b>				<b>22d. LOCATION (City, town, or county)</b> <b>Pocomoke City, Maryland</b> (State)	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Thos. S. Kneass</b>						<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>MAR 7 '61</b>			<b>24b. REGISTRAR'S SIGNATURE</b> <b>Thos. S. Kneass</b>		

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If any further information is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3733

Reg. Dist. No.

03728

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. LENGTH OF STAY IN 1b <u>15 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Martin</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Henrietta</u> First <u>Spencer</u> Middle Last				4. DATE OF DEATH <u>March 3</u> Month Day Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 2-1889</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Centerville, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Kato Jacob</u>				14. MOTHER'S MAIDEN NAME <u>Don't know</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Gabri H. Spencer</u> Address <u>Snow Hill, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420-1</u> DUE TO <u>Coronary disease (probably) Brief</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>N. E. Sartorius</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>N. E. Sartorius</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>March 7/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Clemona Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Way E. Dammis</u> ADDRESS <u>Snow Hill, Md</u>				24a. REC'D BY REGISTRAR <u>Mar 9 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any certificate is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH